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# RECOMMENDATION FOR SUPPLEMENTARY FUNDING FOR PROGRAMMES IN THE ASIA REGION WITHOUT RECOMMENDATIONS FOR FUNDING FROM GENERAL RESOURCES

SUMMARY

This document contains recommendations for supplementary funding in countries in the Asia region for which no recommendations for funding from general resources are requested at the 1991 Executive Board session. The project proposals submitted here are aimed at expanding or complementing ongoing programmes in the countries concerned. The Executive Director recommends that the Executive Board approve supplementary funding in the following amounts for the projects listed below, subject to the availability of specific-purpose contributions.

| Country/programme | Amount (United States dollars) | Duration |
|---|---|---|
| Bangladesh | 48 828 000 | 1991-1993 |
| China | 6 764 000 | 1991-1994 |
| Sri Lanka | 2 000 000 | 1991-1993 |

Summaries of the individual recommendations follow. A table setting out the planned annual phasing of expenditure for each supplementary funding proposal is given at the end of the document.

# I. BANGLADESH

U5MR: 184
IMR: 116
GNP per capita: $170

Child population (0-15 years): 52.5 million
Literacy rate (male/female): 45/19 per cent
Access to health services: 45 per cent

Water supply and sanitation

1. The Government of Bangladesh is committed to achieving universal coverage of rural water supply and sanitation. Since 1972, the Government has consistently implemented a rural water supply and sanitation programme. The impressive improvement in rural water supply means that 131 people get their water per operating tube-well in 1990, down from 417 people per tube-well in 1972, and rural sanitation coverage has risen from zero to approximately 6 per cent during the same period. The Government substantially increased its budget allocation to this sector in 1990 and plans to continue the trend in the fourth five-year plan period (1990-1995), with the goal of achieving accelerated implementation and balanced coverage of water supply between the different hydrogeological regions of the country. The government plan includes sharing of responsibility and cost of installation and maintenance with the beneficiaries to achieve sustainability.

2. To date, the Government, with UNICEF support, has installed and maintained 565,400 hand-pump systems, rehabilitated 160,000 blocked tube-wells and produced and sold over 800,000 water-seal latrines to families/communities at cost. UNICEF also provided technical assistance and support to improve the designs of water and sanitation technologies, develop alternative technologies and hydrogeological mapping of coastal and low water-table areas. UNICEF successfully persuaded the Government to involve the community in programme implementation.

3. The general objectives of the water supply and environmental sanitation programme are to reduce the incidence of diarrhoeal diseases and parasitic infections in children and to strengthen national capacity to provide water supply facilities for rural areas and urban slums and fringes to achieve the maximum possible health impact.

4. The specific objectives are to:

(a) Derive the maximum health impact by more effectively integrating strategies for improving water supply and sanitation services and personal hygiene;

(b) Seek behavioural change through intensive health education, leading to wide-scale adoption of proper sanitation and personal hygiene practices and use of tube-well water for drinking and other purposes;

(c) Increase sanitation coverage from the current levels of 6 per cent to at least 16 per cent throughout the country and to around 30 per cent in areas prone to diarrhoea epidemics;

(d) Increase water supply coverage through the installation of 66,740 new hand-pump systems, the rehabilitation of 45,650 existing hand-pump systems and the proper operation and maintenance of the facilities.

5. The above objectives will be achieved by involving government agencies, in addition to the Department of Public Health Engineering, in programme development and implementation; giving priority to water supply in the coastal belt and low water-table areas where access to safe drinking water is still very poor; strengthening the participatory approach to tube-well installation, which is strategic to ensuring sustainability after the withdrawal of external assistance; and making adjustments in sharing the cost of sinking tube-wells by the Government and beneficiaries, as well as UNICEF, in view of price escalation, to achieve the enhanced physical targets. UNICEF will cooperate with the Government in implementing the six projects described below.

Village sanitation

6. The project will be implemented in all 460 upazilas (subdistricts) of the country by undertaking nation-wide social mobilization and intensive health education and the production and sale, through the government system, of 300,000 to 400,000 water-seal latrine slabs a year. The project will ensure the availability and/or self-help construction each year of a further 1.05 million latrine units of different kinds so as to enhance national coverage to 16 and up to 30 per cent in some selected upazilas. People will be encouraged to build some latrines with local materials, with the rest being provided by private producers and non-governmental organizations (NGOs) at local levels, with limited UNICEF assistance and mass industrial production of plastic units that are sold at subsidized rates through the Department of Public Health Engineering and NGO centres.

Rural water supply and sanitation in the low water-table area

7. The project will be implemented in 200 upazilas and will provide domestic water for approximately 7 million people in rural communities by installing 35,400 deep-set hand-pumps with large platforms, improving coverage to approximately 469 people per operating tube-well; promoting the construction of 354,000 low-cost simple hygienic latrines by beneficiaries of the hand-pumps; and improving the personal hygiene practices of 2.1 million beneficiaries.

Rural water supply and sanitation in the coastal belt

8. The project will be implemented in the 84 coastal belt upazilas and will provide domestic water for approximately 2 million people in rural communities in the coastal belt by installing 8,180 hand-pump systems (including 7,000 deep tube-wells) with large platforms, improving average coverage to approximately 300 persons per operating hand-pump; promoting the construction of 81,800 low-cost simple hygienic latrines by beneficiaries of the hand-pumps; and improving the personal hygiene practices of 500,000 beneficiaries.

Rural water supply and sanitation in the shallow water-table area

9. The project will be implemented in 176 upazilas where the water table lies within 7.75 metres of the surface and where there is no problem of salinity. Upazilas may be added to or deleted from the project after joint agreement by the Government and UNICEF. The project will also provide shallow tube-wells in those upazilas that fall within the scope of UNICEF-assisted projects for rural water supply and sanitation in the coastal belt (84 upazilas) and in the low water-table area (200 upazilas). This project will provide domestic water for approximately 1.27 million people in the shallow water-table area by installing 18,250 shallow hand-pump tube-wells with large platforms and improving average coverage to 81 persons per public hand-pump. It will also promote the construction of 182,500 low-cost simple hygienic latrines by beneficiaries of the hand-pumps and improve the personal hygiene practices of 1 million beneficiaries. UNICEF will assist this project only through the 1992-1993 implementation period, after which the Government will assume responsibility.

Water supply and sanitation in urban slums and fringes

10. The project will commence in the fringe and slum areas of a limited number of pourashavas (municipalities) and gradually expand to 59 pourashavas in the country. It will provide domestic water for approximately 500,000 people in fringe and slum areas of towns by installing 4,640 hand-pump systems. It will also construct 39 latrine production centres where 18,000 water-seal latrine components will be made.

Rural water supply and sanitation maintenance, rehabilitation and upgrading

11. The project will be implemented in all upazilas of the country and its objectives are: (a) to reduce the proportion of inoperative hand-pumps to 3 per cent by training caretaker families, providing tools and spare parts and by transferring the responsibility for maintenance to the beneficiaries; (b) to reduce the proportion of blocked tube-wells to 7 per cent by desanding 45,000 shallow tube-wells, resinking 45,000 shallow tube-wells and rehabilitating 300 deep-set and 350 deep tube-wells; (c) to construct or repair 12,500 platforms of existing deep-set and shallow tube-wells; (d) to enlarge 10,000 existing one-bag platforms in deep tube-wells, shallow tube-wells and deep-set wells; and (e) to upgrade 105 existing unprotected water sources where tube-wells are not feasible.

12. UNICEF will seek an estimated $29.7 million in supplementary funding for the water supply and sanitation programme in the July 1991 to December 1993 period. All six projects will be implemented by the Department of Public Health Engineering of the Ministry of Local Government, Rural Development and Cooperatives.

Education

13. This submission is part of the ongoing universal primary education and non-formal education and functional literacy projects already approved by the Board in 1988 for the 1988-1993 programme. Owing to the accelerated utilization of funds and the enormous needs in this area, and in order to take advantage of the momentum and interest generated by the World Conference on Education for All, this project is being submitted for additional supplementary funding in the amount of $16,171,000 for the period 1991-1993.

14. The Government played an active role in promoting the World Conference on Education for All by hosting the Regional Conference on Education for All for South and Central Asia in early December 1989 in Dhaka, Bangladesh. One outcome was the declaration making primary education compulsory for all up to grade 5. Furthermore, to help reduce the imbalance in the enrolment rates of girls and boys, education was made free for girls in rural areas up to grade 8. This was a significant breakthrough for advocacy on behalf of girls in the South Asian Association for Regional Cooperation Year of the Girl Child 1990. The new fourth five-year national plan reflects these imperatives.

15. Improving the educational level of the population remains a challenge in Bangladesh, a society marked by high population growth and extreme poverty. A telling indicator is the fact that the adult literacy rate has only increased from 25.8 per cent in 1974 to around 31 per cent in 1990. During the same period the absolute number of illiterates increased from 27 million to 46 million in 1990.

16. Primary gross enrolment registered a marginal increase, moving from 60 per cent in 1986 to about 70 per cent in 1990. The ratio of boys to girls in primary schools stands at 56:44. All levels of education are marked by high rates of wastage, with nearly 70 per cent of the children dropping out before completing grade 5. Therefore, the majority of children drop out in the first two grades without attaining even basic literacy or numeracy skills.

17. On average, only around 50 per cent of the children enrolled actually attend school daily. Because school hours and semesters are not adjusted to the hours children work in paid employment or agriculture, during the peak agricultural months (May, August, September and December), school attendance drops even further. Poor parents often cannot forgo the labour of their children. For example, nearly all girls from households that own agricultural land go to school, whereas fewer than 1 out of 10 from poor households attend schools.

18. Some causes of poor enrolment and high drop-out rates are: (a) perceived inadequacy of primary education as a means of alleviating poverty and assisting in the struggle for survival; (b) the poor quality of the teaching-learning process in primary schools; (c) the serious difficulties confronting many children who are unable to bridge the gap between their disadvantaged home environment and the formal primary school situation; (d) inadequate community support and involvement; (e) inadequate

advocacy/social mobilization efforts to stimulate demand for basic education and promote positive attitudes towards education; and (f) limitations in access to educational services in terms of physical facilities, cost and distance.

19. Many of the activities and approaches supported in the 1985-1988 period have continued with a sharpened focus and greater emphasis on qualitative improvement, particularly on innovative approaches, rather than budget support. Stronger linkages between component activities, such as curriculum renewal, the development and production of instructional materials and teacher training, have been built into the programme. Increased enrolment and retention of children from disadvantaged families, especially girls, and active community participation have been demonstrated through the experience of the Bhaluka Satellite School, as well as non-formal schools within easy access to children, established by the Bangladesh Rural Advancement Committee (BRAC) and other NGOs. UNICEF is assisting the mass education project to develop a viable programme and organizational framework for launching a national mass education programme during the fourth five-year plan. A greater effort has been made to create linkages between UNICEF-supported education activities of health, nutrition, water supply and sanitation and women in development to promote child survival and development (CSD).

20. Compulsory universal primary education is the basic goal of the fourth five-year plan (1990-1995) and constitutes the overall framework within which basic education activities, with UNICEF support for 1991-1993, will be implemented. Significant efforts towards universalization of primary education were made in the formal education sector during the second (1980-1985) and third (1985-1990) five-year plan, with substantial allocation of resources (development expenditure increased from 13.3 per cent during 1973-1980 to 46 per cent during the third five-year plan). Gross enrolment, nevertheless, increased only slowly from 58 per cent in 1973 to about 70 per cent in 1990.

21. The government decision to make primary education compulsory, including increased financial allocation (development budget projected at 49 per cent in 1990-1991), has clearly demonstrated its political will and commitment towards universal primary education and education for all during the fourth five-year plan. Making girls' education free up to grade 8 underlines the fact that their education deserves special attention, especially in the light of the low rate of women's literacy and women's important role in the family.

22. The major thrust of the universalization of primary education will be to increase the enrolment and retention of children in schools. With the introduction of compulsory primary education in 1991, it is hoped that all six-year-old children will be enrolled in grade 1 and retained in school until they complete the primary cycle, thus ensuring primary education for all primary-school-age children by the year 1995. The introduction of compulsory primary education will eventually help to eliminate both gender and regional disparities. However, until the objectives are fully met, specific strategies

and interventions will be developed to ensure greater participation of deprived and disadvantaged groups, especially girls, women and the urban poor, in basic education programmes and related activities.

23. Special attention will be given to the promotion of girls' education, literacy and life skills training since, compared with boys, their enrolment is lower and their drop-out rate is higher. The investment in education for girls and women will produce added returns in the form of improved health and nutrition, and increased participation of children in schools. Concerted social mobilization actions will be initiated to help empower women to play an active role in basic education activities.

24. To provide access to primary school for all children, the effective utilization of indigenous institutions, such as mosque-based maktabs, will be pursued. An effective alliance of conventional strategies and innovative approaches will strengthen the process and accelerate achievement of universal primary eduction.

25. To improve the quality and relevance of basic education and make the teaching-learning process more effective, current efforts of curriculum renewal and modification and their application in the classroom, as well as the design and development of instructional materials and teaching aids, will be continued. Special attention will be given to improving teachers' performance through continual teacher-training and other support services.

26. Through decentralization, the Government aims to integrate central-level support, guidance and resources with support and resources from the intermediate level (district and upazila level) and the local level (school management committees and parent/teacher associations) to establish an efficient system that meets the needs of the population.

27. The effective mobilization of all government and non-government initiatives and resources is imperative for achieving universal and compulsory primary education. Collaboration will continue with other agencies such as the United Nations Educational, Scientific and Cultural Organization, the United Nations Development Programme, the World Bank and the Asian Development Bank, in addition to the Norwegian Agency for International Development, the Swedish International Development Authority (SIDA), the Government of the Netherlands, and the Overseas Development Administration.

28. The consolidation of ongoing activities to develop mutually reinforcing programmes in such areas as immunization, efforts to incorporate relevant messages from Facts for Life into curricula, materials and training activities and the special concern for girls' education indicate the strong relationship between basic education and CSD.

29. UNICEF will continue to assist the Government in two broad areas: universalization of primary education and non-formal education and functional literacy. The general education project for the universalization of primary education represents the focus of government efforts in the field of formal primary education development during the fourth five-year plan (1990-1995). It constitutes the overall framework within which activities have been identified for UNICEF assistance for the period 1991-1993, based on the 1988-1993 country programme. It is expected that government efforts to achieve universal primary education will continue to be reflected beyond 1993 by similar major programmes to which UNICEF will provide support. Many activities within the current national programme to achieve universal primary education will need to be continued and sustained through the fifth five-year plan.

30. The ongoing national programme to achieve universal primary education consists of a number of components such as the construction and renovation of primary schools, the training and retraining of teachers and other education personnel, curriculum development, technical assistance, the development and production of textbooks and the provision of instructional materials and teaching aids. These are all essentially designed to expand the formal primary education system and to substantially improve its quality.

31. The programme has been supported by a number of bilateral and multilateral donors, including UNICEF, and by a major loan from the World Bank. UNICEF cooperation will continue to be an integral part of the programme, but will focus on the main areas and concerns that hinder primary education coverage and quality, identified during the implementation of the third five-year plan.

32. A yearly work plan introduced by the Ministry of Education in 1985, is reinforced by a six-monthly work plan for UNICEF-assisted activities. Progress and problems are reviewed on a quarterly basis. The flow of information to and from the field is strengthened by the management information system of the Directorate of Primary Education, and corrective measures are suggested for improved project implementation on a quarterly basis.

33. A project implementation unit has also been created in the Ministry of Education to oversee the implementation of the scheme, review progress, analyse major implementation problems and recommend necessary measures to the Ministry. UNICEF field offices are also involved in monitoring and evaluating the implementation of various components of the project. Small-scale illustrative and evaluative studies will be undertaken as and when required under the various components of the project.

34. An overall government policy on providing educational and learning opportunities outside the formal school system has yet to emerge. Traditionally, non-formal education and literacy activities have been components of the efforts of national and international NGOs, with only limited government intervention and support. Lately, it has been recognized

by the Government that to achieve the goals of education for all and universal primary education, government efforts must be supplemented by strengthened and expanded community and NGO efforts to provide basic education opportunities for out-of-school children, through a non-formal approach, adult literacy and life skills training.

35. The Government has recently decided to mainstream the primary level Islamic religious schools, the Ebtedaee Madrasa, into the primary school system, creating nearly 1.8 million places for primary-school-age children. Similarly, the maktabs (mosque-based schools) could provide primary education to another 1 million; the private rural primary schools have 1.5 million pupils. The capacity that exists in these and other facilities, as well as in government primary schools, can accommodate nearly 16.5 million primary-school-age children and make primary education universal by the year 2000.

36. Activities will, therefore, include the development of maktab education and non-formal basic education, a national literacy programme, early childhood education and preparation for school and community-based learning activities. A six-monthly work plan and performance assessment table are being used to plan activities with UNICEF support and review implementation on a regular basis by the Ministry of Education.

Women's health and development programme

37. The Government has requested UNICEF to assist BRAC, the largest NGO in the country, in view of its proven ability to work effectively at the grass-roots level and to target the poorest of the poor, in providing a package of interventions for women's health and development. The ultimate aim is to reduce maternal and infant/child mortality while developing a local capacity to sustain the results.

38. Specific objectives of the women's health and development programme are: (a) to reduce the maternal mortality rate (MMR); (b) to reduce the infant and child mortality rate and decrease the incidence of low birth-weight babies; (c) to increase immunization coverage of children under one year old and pregnant women to 85 per cent; (d) to increase the contraceptive prevalence rate for modern methods to 50 per cent; (e) to increase vitamin A distribution to children under five years old to 80 per cent; and (f) to diagnose and treat 75 per cent of tuberculosis cases and 75 per cent of pneumonia cases in the pilot area.

39. The programme will be carried out in 15 upazilas, clustered in groups of four or five, covering a population of approximately 3 million in almost 2,250 villages. The 15 upazilas will be selected on the basis of need and the interest of their populations in participating actively in the programme. In 2 of the 15 upazilas, intensive interventions will be made to reduce maternal mortality, while in another two, special interventions will be made to reduce respiratory infections, particularly pneumonia. In addition, 15 teams will serve as facilitators, assisting the public sector in up to 90 upazilas and

municipalities that continue to have less than the desired level of immunization coverage. The present primary health care programme under the child survival project and the rural development programme will continue with reduced staff involvement until it is handed over in full to the rural development programme in one year.

40. The following activities will be undertaken: a health cadre of 30 village women will be trained in each of the 2,250 villages; a village health worker will be trained in each village; effective village committees and mothers' clubs will be established in 2,250 villages.

41. Using a community-based approach, the programme will call upon the experience and expertise of BRAC to address effectively the complex and varied problems facing the rural poor. Special emphasis will be given to the landless and the assetless poor, as BRAC has in all its development projects since 1976, and the programme will draw heavily on the services of women and direct a significant portion of its services to women, as a programme by women for women. Particular emphasis will be placed on improving pre-natal care and delivery practices in order to reduce the high MMR.

42. The programme will also be integrated, combining literacy and education with rural development, credit and income generation, and incorporating preventive, promotive and some curative interventions. BRAC has proven its ability to establish strong community-based organizations that can assume responsibility for local development activities. That, and its recent success with rural credit, greatly increase the chances that the programme can be sustained.

43. The women's health and development programme is expected to operate for a minimum of three years and, if targets are not met, for four years. After it ends, the rural development programme will assume the functions of the health and development programme for four more years, during which time all health and development activities will continue with reduced input from BRAC. At the end of seven or eight years when the BRAC bank takes over, the programme should be self-sustaining. Major programme components are listed below.

Education

44. A group of 30 adolescent girls (11 to 16 years of age) from low-income households will be selected in each village to learn functional literacy, numeracy, credit and social studies during a 20-month period. Training will also be given in proper health/nutrition practices and in how to monitor the health status of mothers and young children, including growth monitoring practices. Once trained, the 30 young women will serve as their village's health cadre, each of them responsible for 7 to 10 households near her home. To prepare them for future rural development activities and to consolidate their interest in the programme, a loan and credit scheme will also be introduced. An interesting feature of the project is that the parents of each girl will be asked to sign a contract agreeing that their daughter will not marry until she completes the 20-month non-formal primary education course.

If the contract is broken, the parents have to pay BRAC monetary compensation. After the women's health and development programme ends, the education programme will continue as part of the rural development programme.

Health, nutrition and family planning

45. Each of the 2,250 villages participating in the women's health and development programme will have at least one trained traditional birth attendant (TBA). BRAC has developed a seven-day training course for TBAs, reinforced by a one-day refresher training session each month. The cadre, the village committee and the mothers' clubs will all help to link the community with the public health structure, mobilizing the community for immunization activities and vitamin A distribution. Counselling on family planning will also be provided. In addition to ensuring that all children are fully immunized by the age of one year, a concerted effort will also be made to immunize all women between the ages of 15 and 45 years with tetanus toxoid. During a child's first year, 50,000 international units of vitamin A will be given with each dose of the combined diphtheria/pertussis/tetanus vaccine, and 100,000 international units with the measles immunization at 9 months to test whether such a boost in vitamin A stores will protect the child during the first three years of life, the period of maximum vulnerability to infection. The TBA in each village will also play a role in organizing pre-natal care centres for pregnant women and all pregnant women will receive iron, folic acid tablets and at least two doses of tetanus toxoid vaccine. Special efforts will be made to identify mothers who are at high risk and they will be referred to union family welfare centres or upazila health complexes and district hospitals.

46. In the two upazilas where special efforts to reduce maternal mortality are to be made, women found to be severely underweight will receive 30 kilograms of wheat each as a special family ration each month (using wheat provided by the World Food Programme) to address the problem of low birth weight.

47. TBAs will also be trained in detecting acute respiratory infections (ARI) and tuberculosis, referral to clinics and monitoring of treatment. Health and nutrition education will also be emphasized. Knowledge, attitude and practice studies will also be undertaken to develop the most effective strategies and communication content of messages.

48. Another activity to be tried on a pilot basis is the drug cooperative, which village organizations will be encouraged to set up in each union. After successful implementation in a small area, this will be replicated. Sanitation, family planning and the management of health services activities will also be promoted. Information, education and communication will be included in all activities. Meetings will be held on various topics concerning women, such as health, nutrition and family planning.

49. Establishing links with government officials and workers will be one of the major challenges for the women's health and development programme. At the national level, liaison with the directorates of health and family planning will be maintained through personal contacts and consultative meetings. At the district level, BRAC workers will participate in all the relevant meetings and forums organized by the health and family planning authority. BRAC will also collaborate closely with upazila/union-level health and family planning personnel. Village organizations, fully involved with planning and management, especially of health activities, will be formed. Rural credit from the BRAC Bank will be an option, and BRAC will assist the community in establishing the economic foundation that will be required to support health-related services and activities no longer totally dependent on outside resources and technical assistance.

Monitoring and research

50. If the programme strategy is to be replicated elsewhere in Bangladesh, the most effective ways of integrating the various components of the approach (education, community organization and mobilization, mothers and infant/child health interventions, public sector facilitation, credit and development activities) must be studied and recorded.

51. UNICEF will seek $3 million for three years to support BRAC in the women's health and development programme.

## II. CHINA

| | |
|---|---|
| U5MR: 43 | Child population (0-15 years): 327 million |
| IMR: 31 | Literacy rate (male/female): 83/59 per cent |
| GNP per capita: $330 | Access to health services: 90 per cent |

Strengthening maternal and child health/family planning services at the grass-roots level

52. This project, which is being implemented by the Maternal and Child Health (MCH) Department of the Ministry of Public Health, seeks to lower maternal and child mortality and morbidity and improve nutrition in some of the most needy areas of China. Activities will focus on 300 of the poorest, most remote counties in China, with a population of over 100 million people, and which include many minority areas. While the majority of the counties are found in the north-west and south-west of the country, the Ministry of Public Health has included counties from all 27 provinces in the country. The counties selected meet the following criteria: an infant mortality rate (IMR) over 50 per 1,000 live births; a birth rate greater than 25 per 1,000 population; and per capita income below 300 yuan renminbi per year, which is less than one half the national average of 650 yuan renminbi.

53. The principal objective is to strengthen the three-tier - county, township and village - MCH service delivery network. This will be accomplished by (a) strengthening the coordination, management and supervision of the service delivery system; (b) promoting institution building and training, especially at the grass-roots level; (c) improving the management information system; (d) strengthening the provision of health education activities; (e) providing essential equipment; and (f) implementing selected applied research projects. An external evaluation by the Shanghai Medical University is planned, whose recommendations, along with routine monitoring visits by UNICEF/United Nations Population Fund (UNFPA) and the Ministry of Public Health, will play an important role in project management decisions.

54. Training is one of the most essential project components and, working closely with UNICEF/UNFPA staff, the MCH Department is developing training materials for use in all 300 counties for the first time. These materials, targeted for township and village doctors, use a variety of newly introduced training methods, more appropriate than the lecture method for adult audiences. The modules developed in the first year focus on breast-feeding, the control of diarrhoeal diseases (CDD), ARI, safe motherhood and family planning/child spacing. In subsequent years, training will cover growth monitoring, infant and child nutrition, establishment of a simplified MCH information system, use of data for management purposes and reinforcement and extension of the initial year's modules.

55. All the villages and townships will be provided with equipment, such as delivery bags and weighing scales for newly retrained MCH workers, to achieve a basic level of primary health care, with most of the funds made available by local and provincial governments. The Ministry of Public Health has established guidelines for such equipment. The relatively limited international assistance for each county will be used to provide vehicles for supervisory staff at the county level, training equipment and some essential back-up medical equipment for the referral MCH centre at the county level. In addition, UNICEF has agreed to supply tetanus toxoid vaccines to the 300 counties in a joint effort with the expanded programme on immunization.

56. The above strategies and activities are expected to improve significantly MCH services in all 300 disadvantaged counties. As a result, in five years it is expected that IMR and MMR will each decline by at least one third and that growth retardation will be substantially reduced. Such progress in the poorest parts of the country will be a major contribution to achieving the health goals for the 1990s in China.

57. An important aspect of the project is the extensive commitment that has been made by the Government and health system at all levels. The MCH Department has mobilized technical experts and project managers at national, regional, provincial and county levels. In addition, county and provincial governors have been oriented to project objectives and priorities and have pledged their support. In financial terms, the country's combined commitment from national, provincial, prefectural and county levels is three times that of the United Nations contribution. Probably of even greater significance is

the increased awareness, visibility and priority given to services for children and women in these disadvantaged areas as a result of the mobilization process of the project.

58. UNICEF, UNFPA and the World Health Organization (WHO) have worked together and with the Government to formulate this project. WHO will provide technical assistance, under a separate agreement with UNFPA, in three project components (management information systems, evaluation and MCH professional curriculum development). In addition, UNFPA will employ the services of the Programmes for Appropriate Technology in Health to develop two curricula appropriate for the Chinese situation and, working collaboratively with Chinese counterparts, to hold training workshops for regional and provincial MCH workers. UNFPA is also funding the evaluation activities of the Shanghai Medical University School of Public Health, which will work with WHO consultants to implement a variety of evaluation activities.

## III. SRI LANKA

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|---|---|
| U5MR: 43 | Child population (0-15 years): 5.9 million |
| IMR: 32 | Literacy rate (male/female): 91/83 per cent |
| GNP per capita: $400 | Access to health services: 93 per cent |

### The situation of children and women on estates

59. The resident population on state-owned estates was estimated at 751,000 in 1989, two thirds of whom are of Indian origin. (An estate is a tea or rubber plantation unit consisting of about 50 acres. The two state agencies - Janatha Estates Development Board and the Sri Lanka State Plantations Corporation - cover 51 per cent of the estate sector in Sri Lanka.) Children under five years old account for 15 per cent and women more than 50 per cent of the total population on estates. The Government is firmly committed to improving the social development of this long isolated minority group and its efforts have been strongly supported by UNICEF, donor countries and NGOs.

60. During the past decade, the health status of women and children on state-owned estates has improved. IMR, for example, declined from 104 per 1,000 live births in 1975 to 43 in 1989, although it was still higher than the national average of 32. MMR, however, declined slowly from 470 per 100,000 live births in 1975 to 300 in 1989, a rate far higher than the national average of 60. Nutrition levels are low both on estates and nation-wide, but the situation on estates is clearly worse, with a 33 per cent incidence of low weight births (below 2.5 kilograms compared with a 21 per cent incidence nation-wide. In addition, about 68 per cent of pregnant women on estates were seriously anaemic. A similar gap also exists in education. While the country has achieved a high literacy rate of 86 per cent and a primary school enrolment rate above 90 per cent, the levels on estates remain at 65 and 62 per cent, respectively. Government policy is to absorb estate

minorities into the mainstream and bridge all these gaps expeditiously. Under the medium-term investment programme for the overall development of the estate sector, a total input of $212 million was planned for the period 1985-1989.

61. However, current civil conflicts in the country have impeded progress. The loss of estate income that has resulted from the conflict has not only added to the economic difficulties of the country, but also left little profit with which estates can finance their own social development activities. Therefore, UNICEF and donors continued support is requested by the Government to maintain the achievements already made and to further reduce the gaps between estate and national indicators.

Past cooperation

62. The UNICEF programme for women and children on estates, begun in 1984 with a total allocation of $2.1 million, was financed jointly by the Governments of the Netherlands and Norway. By mid-1991, the funds for the programme will be fully expended.

63. The stimulus provided by the UNICEF-assisted programme has resulted in the two state agencies increasing allocations for social welfare and development, upgrading and making functional all crèches to provide child care and other health and welfare services. Using the crèche as an entry point, UNICEF support was expanded to cover a wider range of MCH activities, including nutrition and water supply and sanitation efforts.

64. Under MCH services a structure has been established to strengthen maternal care, immunization services and nutrition and health education. The estate paramedical staff were trained to conduct regular clinics for pregnant women in their health centres. Regional vaccine centres were established in each of the plantation regions and vaccines are distributed to all plantations and neighbouring villages. Midwives, crèche attendants and family welfare supervisors have been trained to work with estate medical assistants in conducting health education programmes for the resident population.

65. With the strengthening of the health and welfare infrastructure on each plantation, it has been possible to involve the community in health and welfare activities. The formation of worker-level committees was encouraged so needs could be articulated and self-help programmes formulated. Meanwhile, a change in the attitude of plantation management towards labour has taken place, with managers realizing that a healthy and contented labour force helps the system function more efficiently.

66. For the provision of safe water and sanitation facilities, UNICEF assisted in the construction of water schemes and latrines on 15 demonstration plantations. Water sources were protected and water supplied through closed wells with hand-pumps or tap-stands in the vicinity of living quarters. UNICEF also assisted in the construction and repair of one latrine per family.

67. Primary schools on the estates are controlled by the Ministry of Education. Distance education programmes have been supported by SIDA. Efforts have been made to improve participation and reduce the high drop-out rates in selected schools, but overall progress is far from satisfactory. Closer cooperation is needed between the two state agencies responsible for estates, the provincial councils and the ministry.

Proposed cooperation

68. The new proposal for 1991-1993 aims to reduce the IMR to well below 40 per 1,000 live births and MMR to below 100 per 100,000 live births; to reduce malnutrition; and to increase the rate of primary school enrolment on the 15 demonstration estates to equal the national rate. A two-pronged strategy will be adopted. Health, nutrition and crèche services will be provided to all estate women and children. Interventions in water supply, sanitation and education will be provided only on the demonstration estates.

69. MCH will be improved. The proportion of births in institutions will be raised from 70 to 80 per cent by the end of 1993 on estates and attempts will also be made to ensure that births outside institutions receive trained assistance. UNICEF will provide essential equipment, drugs and supplies to medical institutions and maternity wards. Estate medical staff will receive refresher training in health education, growth monitoring, immunization, diarrhoea management, maternal health and the birth information system. Specific training programmes will be organized on combating ARI, the main cause of child deaths on estates.

70. Universal child immunization will be sustained. Vaccines will be provided and cold-chain equipment will be replaced where necessary. The service delivery system will be strengthened to reach all children and pregnant women on the plantations and to extend services to people in neighbouring villages.

71. Growth monitoring will be the main intervention for nutrition promotion. A copy of the growth chart will be given to each mother and its signficiance and use explained to her regularly. Mothers whose children are at risk will receive nutritional supplements from the estate. The establishment of crèche gardens will be encouraged so that produce from the gardens can support feeding programmes in the crèches.

72. Interventions for anaemia will include the provision of iron tablets, folic acid and food supplements, especially for pregnant women. Improved diets will be encouraged through the consumption of locally grown nutritious foods. A nutrition surveillance system will also be established in estate clinics.

73. The CDD project has two main components: education extended to estate management, health personnel and mothers on the importance of safe water, proper sanitation, hygiene and early treatment at home using the indigenous "rice cunjee"; and at the clinical level, using jeevanee (ORS). Breast-feeding

and proper weaning practices will also be promoted. The mother will be considered as the first link in the care of the child at the home level and, thus, will receive appropriate support from estate staff.

74. Crèche services will be upgraded by training 1,600 crèche workers at the regional level, with support from NGOs. The training, with a strong practical orientation, will cover child health, nutrition, environmental sanitation, interpersonal communication and self-reliance. Evaluations will also be carried out on how the basic toys and play materials supplied to the 1,600 upgraded estate crèches can be better used to promote child development.

75. In primary education, facilities will be upgraded to provide improved learning opportunities. School furniture and teaching aids will be provided, and teachers' training and the development of appropriate curricula will be supported to improve teaching standards. Studies will be undertaken to determine the cause of non-participation and alternative methods will be developed at the community level to reduce drop-out rates. Non-formal education will focus on functional literacy, particularly for women and early school drop-outs.

76. To improve the provision of water supply and sanitation, the focus will be on upgrading existing facilities and providing new facilities to primary schools on estates where needed. An information and education package, including Facts for Life, will be provided for the whole community, with the health education component emphasizing information on the proper storage and utilization of water, hygiene practices, food hygiene and clean home environment.

77. Community participation will be emphasized on all the demonstration estates and their experience will be replicated on other estates within a region. The project is an integral part of the Government's medium-term investment programme for the estates. The Sri Lanka State Plantations Corporation and the Janatha Estates Development Board will be the two main agencies for programme administration, management, coordination and supervision.

Estimated annual expenditure

(In thousands of United States dollars)

| Country/programme | 1991 | 1992 | 1993 | 1994 | Total |
|---|---|---|---|---|---|
| Bangladesh | | | | | |
| Water supply and sanitation | 11 720 | 14 637 | 3 300 | - | 29 657 |
| Education | 2 540 | 7 335 | 6 296 | - | 16 171 |
| Women's health and development | 1 074 | 1 132 | 794 | - | 3 000 |
| Subtotal | 15 334 | 23 104 | 10 390 | - | 48 828 |
| China | | | | | |
| Strengthening MCH/FP services at the grass-roots level | 1 861 | 1 688 | 1 698 | 1 517 | 6 764 |
| Sri Lanka | | | | | |
| Services for children and women on estates | 650 | 690 | 660 | - | 2 000 |
| Total | 17 845 | 25 482 | 12 748 | 1 517 | 57 592 |

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